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Statistical Bulletin

METROPOLITAN LIFE INSURANCE COMPANY

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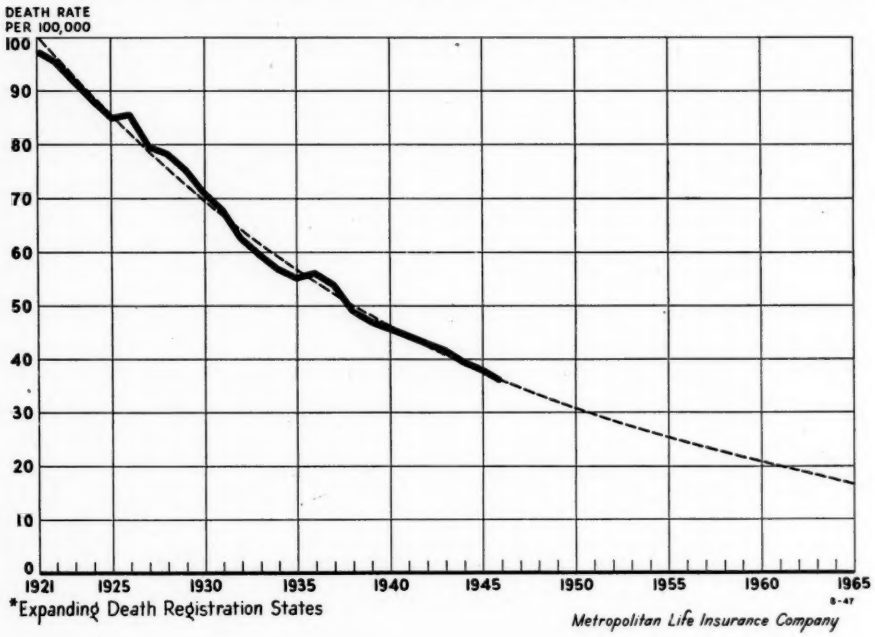
The Tuberculosis Problem—Retrospect and Prospect

THE most convincing evidence that tuberculosis can be reduced to vanishing proportions in our country, both as a cause of death and as a cause of sickness, is the extraordinary progress which has already been made against the disease. As the chart on page 2 shows, the death rate from tuberculosis in the United States has declined with virtually no interruption in the past quarter of a century, despite the widespread economic depression of the 1930's and the trying war years of the 1940's. In 1921 the death rate from the disease was not far from 100 per 100,000 population; by 1946 the death rate had decreased to little more than 35 per 100,000, a reduction of nearly two thirds in 25 years. It is also apparent from the chart that a continuation of the trend since 1921 would bring the death rate from the disease to about 15 per 100,000 in less than two decades from the present. Actually, there are definite possibilities that the improvement in mortality in the immediate future may be even more rapid than in the past. For example, among the many million Industrial policyholders of the Metropolitan Life Insurance Company, the percent decline in tuberculosis mortality so far in 1947 has been more than twice the average annual reduction in the past decade.

The decline in the death rate from the disease in the past 10 years has been countrywide. As is evident from the table on page 3, every State in the Union, without exception, shared in the improvement. One quarter of the States recorded reductions of from 30 up to 40 percent; about one half the States registered declines of from 40 to 50 percent; three States (Iowa, Idaho, and North Carolina) succeeded in cutting their rates by at least 50 percent. In general, the largest gains were made by the States which traditionally have had the best records.

How successful the antituberculosis campaign has been, is also evidenced by the fact that 17 States, fully one third of the total, registered death rates under 30 per 100,000 in 1946. Of this number, eight recorded rates of less than 20 per 100,000, as compared with only two States in this class a decade earlier. There are many counties in the

DECLINE IN TUBERCULOSIS MORTALITY IN THE UNITED STATES* SINCE 1921



United States where tuberculosis has already been practically eradicated. Beyond doubt, decisive victories have been scored against the disease which only a few decades ago constituted the chief threat to the life of the American people.

The outlook for further progress, as already indicated, is very favorable. But it would be a serious error to understate the size of the task that still confronts the antituberculosis movement. There are even now at least 500,000 active cases of the disease in the general population of the country; well in excess of 100,000 new cases are reported each year. In 1946 there were still 50,000 deaths attributed to tuberculosis.

The battle against tuberculosis, if it is to achieve the greatest gains in the shortest time, calls for intensified efforts among those groups in the population in which the problem is now largely concentrated. The nonwhite population now constitutes an outstanding focus of the disease. Although these people comprise about one tenth of the total population, they contribute more than one fourth of all the deaths from tuberculosis. A reduction in mortality among nonwhites to the level of that for whites would bring about a decrease of almost one fifth in the total death rate from the disease. The people of Mexican origin, who live for the most part along our southwestern border, likewise suffer a high tuberculosis death

rate, even higher than that for Negroes in many areas.

Among white persons, the tuberculosis problem is now concentrated largely among men in middle and later life. In 1945, of the 25,055 deaths from the disease among white males, 20,067 occurred at ages 35 and over. Among men aged 35 to 64 tuberculosis is outranked only by heart disease, cancer, and accidents. It is a significant fact that, although the improvement in mortality at the older ages has been material in the past few decades, it has not been as large as the improvement at the younger ages. In the light of these facts, intensified antituberculosis work among men over age 35 promises large dividends in life conservation, and this is particularly true in urban areas where the effect of industrial life makes itself felt.

The time is ripe for an all-out war to stamp out tuberculosis in our country. This will require fuller and

MORTALITY FROM TUBERCULOSIS—ALL FORMS. RECORDED BY STATES IN 1946 AND 1936. (RANKED IN ORDER OF DEATH RATE IN 1946)

STATE	DEATH RATE PER 100,000		PERCENT DECREASE	STATE	DEATH RATE PER 100,000		PERCENT DECREASE
	1946†	1936			1946†	1936	
UNITED STATES	35.9	55.9	36	Washington	34.2	50.5	32
				Ohio	34.2	51.7	34
Wyoming	9.1	17.7	49	Pennsylvania	34.6	48.5	29
Utah	10.8	21.1	49	South Dakota	35.1	38.4	9
Iowa	12.1	24.3	50	Arkansas	35.8	58.8	39
Idaho	12.3	24.9	51	Vermont	36.0	45.5	21
Nebraska	13.6	18.6	27	Illinois	36.1	52.1	31
North Dakota	16.2	26.9	40	Massachusetts	36.5	43 9	17
Kansas	16.2	28.9	44	New Jersey	38.2	52.3	27
Oregon	18.6	36.2	49	West Virginia	38.7	53.4	28
Wisconsin	21.0	35.3	41	Alabama	39.0	65.8	41
Minnesota	21.1	35.8	41	California	40.6	72.9	44
New Hampshire	22.8	35.9	36	Texas	40.8	71.1	43
Maine	24.3	40.9	41	New York	41.6	57.5	28
Connecticut	28.3	41.3	31	Virginia	42.2	72.9	42
Indiana	28.9	50.8	43	Delaware	44.7	50.7	12
Florida	29.7	54.3	45	Louisiana	44.7	68.1	34
Rhode Island	29.8	47.6	37	Nevada	45 0	86.4	48
North Carolina	29.9	61.5	51	Colorado	46.0	76.2	40
South Carolina	30.0	55.9	46	Maryland	52.4*	81.8	36
Michigan	30.3	43.2	30	Tennessee	52.4	92.2	43
Oklahoma	30.4	54.6	44	Kentucky	57.3	75.8	24
Montana	31.6	40.6	22	District of Columbia	62.2*	104.4	40
Mississippi	32.9	60.6	46	New Mexico	86.0	105.1	18
Georgia	33.0	56.9	42	Arizona	144.8	235.1	38
Missouri	33.7	61.7	45				

*Deaths of District of Columbia residents which occurred at Glenn Dale Sanatorium in Maryland have been added to the deaths which occurred in the District of Columbia and subtracted from the number which occurred in Maryland.

†The rates for 1946 are based on provisional numbers of deaths provided by State health departments to the National Tuberculosis Association.

more intensive utilization of the knowledge and the methods which have already proved so effective in the prevention and the treatment of the disease. Case finding will continue to be a basic weapon, but the development of mass X-ray examinations makes it feasible for the search to be extended to the entire population, and for the procedure to be repeated periodically in order to detect new cases. Adequate and continuous medical care of patients will continue to be fundamental in the war against tuberculosis; this will require not only more sanatorium facilities, but also accommodations such as will encourage patients to stay until their disease is arrested. The vocational rehabilitation of the patient must be given a more central place in the program, so that when he is discharged from the sanatorium he can be placed in gainful employment within his physical capacity. In those groups where the disease is still widely prevalent the proposed use of BCG holds good promise. Side by side with these specific measures, and supplementing them, is the general effort to provide better housing and better living and working conditions generally for the peole of our country.

The Chances of Being Born Alive

STILLBIRTHS are of much greater importance in the total mortality picture than is generally realized. Although the ratio of stillbirths to live births has been declining in recent years, the number of children born dead in our country (about 65,500) is still more than 10 times the number of women who die from puerperal causes in a year. Stillbirths continue to be a serious and challenging problem for medical science and public health administration.

The chances that a child will be born alive are determined by a variety of factors. One of them is the order of birth. For some yet unknown reason, the chances are best for the second child and decrease progressively for each successive child. The chances of the first born are lower than of either the second or the third child. The figures for stillbirths for the period 1940-1944 are shown in the table on page 5. Whereas the stillbirth ratio among second children was 18.5 per 1,000 live births, the ratio for the first born was 24.4 per 1,000, or about one third greater. Births of the seventh order were twice as likely to be stillborn as were births of the second order, while for tenth and later children the ratio was three times as great.

The figures cited reflect much less the influence of the order of birth than the influence of the age of the mother, which naturally is higher for children of higher order. The fact is that the age of the mother is much more important than the order of birth in the incidence of stillbirths. In the aggregate, the probability of a child being born alive is highest

when the mother is in the age group 20 to 24 years. As compared with the stillbirth ratio at these ages, the ratio at ages 30 to 34 is more than 50 percent greater; at ages 35 to 39, it is more than twice as great; at 40 to 44 it is three times as great, and among women 45 and over the ratio is at least four times that among women 20 to 24. The tendency of the stillbirth ratio to rise with the increasing age of the mother is especially marked for first births. For example, women who bear a first child after attaining age 45 suffer a stillbirth ratio more than five times that experienced by mothers at ages 20 to 24 years.

The stillbirth ratio is relatively high not only among those who postpone motherhood until the later childbearing ages and those who bear children rather early in life, but also among those who bear a large number of children in rapid succession. Thus, mothers under 20 who bear their fourth child, show a considerably higher stillbirth ratio than do mothers at every other age group up to 40 years. The same is true for women who bear their sixth or seventh child as early as 20-24 years. Other illustrations are to be found in the accompanying table.

STILLBIRTH RATIOS PER 1,000 LIVE BIRTHS BY ORDER OF BIRTH* AND AGE OF MOTHER. WHITE PERSONS. UNITED STATES (EXCLUSIVE OF MASSACHUSETTS) 1940-1944

ORDER OF BIRTH	AGE OF MOTHER								
	All Ages	Under 15	15–19	20–24	25–29	30–34	35–39	40–44	45 and Over
Total	24.4	32.9	21.3	18.5	21.4	28.2	39.3	55.7	80.4
1st	24.4	32.3	21.1	19.9	25.4	37.1	53.3	75.0	104.6
2d	18.5	†	20.5	15.0	16.5	21.6	32.1	50.4	69.3
3d	22.7	—	28.0	18.2	19.0	25.0	34.5	52.4	93.2
4th	27.2	—	43.4	22.2	22.0	27.2	37.8	53.4	93.2
5th	30.6	—	57.1	27.9	23.8	28.3	38.5	55.3	84.9
6th	33.2	—	64.9	39.4	27.1	28.9	37.5	49.8	80.2
7th	35.8	—	†	48.9	30.1	30.5	37.5	50.8	77.7
8th	39.3	—	—	74.6	38.8	33.0	37.8	51.2	82.4
9th	43.0	—	—	74.1	49.9	38.1	38.5	53.5	66.7
10th and Over	58.1	—	—	†	71.4	54.0	52.3	61.5	77.5

*The Federal Government tabulates stillbirths strictly according to parity, taking into account all preceding births reported, whether they were live births or stillbirths. Live births, however, are classified according to the order of live births only, disregarding any stillbirths that may have intervened. This disparity, it is believed, does not materially affect the results.

†Number of cases too few to be significant.

The reduction in stillbirths already achieved is a source of satisfaction, but it must be realized that there is still a great deal of room for further accomplishment in this field of life conservation. Prospective mothers can materially reduce the hazard of stillbirth by seeking medical care early in their pregnancy. This is particularly important for women at both extremes of the childbearing ages, at which periods, as has already been clearly shown, the chances of stillbirth are relatively high. Syphilis is one of the major factors in causing stillbirth, and the early and effective treatment of this disease in infected pregnant women would contribute very considerably to the solution of the stillbirth problem. It should be remembered that the death rate among mothers of stillborn children is also very high; thus, in saving the lives of unborn children we would also save the lives of mothers.

Cost of the Common Cold

THE common cold is the most prevalent and the most highly infectious of all the communicable diseases. Owing to its relatively mild character, the common cold is not a reportable disease, and consequently there are no reliable statistics concerning its incidence for the country as a whole or even for any large geographic area. Nevertheless, it is possible, on the basis of studies made by various investigators among wage-earners, students, and other special groups, to arrive at broad estimates of the incidence and the cost of the common cold in the United States. The figures are very high indeed.

There is general agreement among investigators in this field that the average person suffers at least two colds in the course of a year. This means that in the general population of the country, there are probably not far from 300,000,000 colds annually. The duration of a simple cold averages about five days. Thus, multiplying the number of colds by their duration, one finds that the people of the United States each year suffer about 1,500,000,000 days of discomfort and reduced efficiency, if not of actual disability, from this cause.

Although wage-earners often endure colds without staying away from work, the common cold is nevertheless responsible for more lost time in industry than is any other single cause of disability. Various studies indicate that from 40 to 50 percent of all days lost from work are attributable to colds and their complications. It has been conservatively estimated that the toll of the common cold in this country is at least one working day per employee per annum. If that is so, there will be more than 60,000,000 days lost to industry this year because of colds. Even at an average daily wage of $7, the loss in wages totals more than $420,000,000.

The cost of drugs and medical

care must also be added. Accurate statistics on this subject are not available, so that it is necessary to resort to speculative estimates. On the assumption that every family in the United States spends on an average of $10 a year for drugs and medical care in the treatment of colds, the total amount spent for these items would be in the neighborhood of $400,000,000.

Another factor which enters into the accounting, is the cost to employers resulting from lost production and disrupted routine. This item is extremely difficult to estimate, and no attempt is made here to give even approximate figures. It is certain, however, that the annual cost of colds to employers is very considerable for the country as a whole.

On the basis of the figures cited above, it is thus estimated that the cost of the common cold to the American people is well over a billion dollars a year. Although the common cold is generally considered a minor infection, any disease that runs to such astronomical figures in cost must be rated high in the list of enemies of the public health.

Motorcycle Accident Fatalities Increase Sharply

THE public safety movement apparently needs to give added emphasis in its program to the prevention of motorcycle accidents. This need is underscored by the results of a study among the Industrial policyholders of the Metropolitan Life Insurance Company, which shows that the mortality from motorcycle accidents* increased sharply in 1946 and reached its highest level in at least 15 years. Among male policyholders ages 1 to 74, the death rate from this cause last year was 16.4 per 1,000,000, as compared with 10.6 in 1945 and 6.0 in 1944. It is true that the death rate fell off sharply in the war years, when large numbers of policyholders were in military service, but it is also true that the rate last year exceeded that for 1941, namely, 13.6 per 1,000,000, the previous high in the 15 years under review.

Fatalities in accidents in which a motorcycle is involved are responsible for only 2 or 3 percent of all fatalities chargeable annually to motor vehicles in the United States. Nevertheless, the number of deaths a year in accidents involving a motorcycle is appreciable. Upward of 1,000 persons, it is estimated, were killed in accidents of this kind in the general population of our country in 1946. Moreover, in relation to the number of vehicles of each type on the road, deaths in accidents in which a motorcycle is involved are far more numerous than those in which an automobile is involved.

Efforts to reduce the toll of life exacted by motorcycle accidents should be directed particularly to

*Includes fatalities in accidents in which a motorcycle, motor scooter, or motorized bicycle was involved.

young men, among whom the problem is largely concentrated. According to the experience among Metropolitan Industrial policyholders referred to earlier in this article, of the total who were killed last year in accidents involving a motorcycle, more than 70 percent were males in the age range 15 to 34 years. The age period of maximum mortality was 20 to 24, at which the death rate from motorcycle accidents was 51.2 per 1,000,000 insured males; at ages 15 to 19 the figure was 36.6 per 1,000,000, and at 25 to 34 years it was 21.6. Naturally, relatively few females are killed in motorcycle accidents. The death rate from this cause among male policyholders was about 12 times the rate among the females.

Particularly applicable to motorcyclists is the slogan, "The life you save may be your own." In this insurance experience nine out of every 10 killed in motorcycle accidents were occupants of the vehicle, either as drivers or as passengers. Only seven policyholders, less than 6 percent of the total fatally injured in such accidents were pedestrians struck by a motorcycle. There were a few deaths also of policyholders injured while riding in automobiles in collision with motorcycles. In collisions between motorcycles and automobiles, the fatalities, as one would expect, are much more likely to be among those riding in the lighter vehicle.

Collisions of motorcycles with other vehicles, mostly automobiles, accounted for about half of the deaths in this study. Almost as many deaths were due to accidents in which the motorcycle turned over or struck a tree, post, fence or other fixed object.

The problems of preventing motorcycle accidents are essentially the same as those of preventing automobile accidents. A due regard for safety must be inculcated in drivers so that they will not take unnecessary chances and expose themselves and their fellow passengers to the dangers of serious injury and death. Motorcyclists should be made keenly aware of the increased hazards which attend driving on wet and icy roads, driving too fast, weaving in and out of traffic, disregarding traffic lights and signs, and driving machines in poor mechanical condition.

Decline in Mortality from Toxic Goiter

DISTINCT progress has been made in recent years in reducing the mortality from toxic goiter. Among the Industrial policyholders of the Metropolitan Life Insurance Company the adjusted death rate from this cause at 1 to 74 years declined from 1.9 per 100,000 in 1940 to 1.1 in 1946, a reduction of more than 40 percent. This favorable experience is particularly noteworthy because for a decade prior, the death rate showed little improvement, fluctuating about an average of 2.4 per 100,000. The trend among these insured persons parallels that for the

TABLE 1—DEATH RATES PER 100,000 FROM TOXIC GOITER. BY COLOR, SEX, AND AGE. 1946 AND 1940. METROPOLITAN LIFE INSURANCE COMPANY, WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS

AGE PERIOD YEARS	WHITE				COLORED			
	Males		Females		Males		Females	
	1946	1940	1946	1940	1946	1940	1946	1940
1 to 74*	0.4	0.7	1.6	3.0	0.3	1.0	2.5	3.7
25 to 34	.2	.6	.5	.6	—	.7	3.3	3.5
35 to 44	.7	1.3	1.2	2.6	1.2	1.3	3.6	4.9
45 to 54	1.4	2.0	3.9	8.9	0.7	2.5	7.4	8.6
55 to 64	1.6	1.6	7.3	14.2	1.1	5.3	4.0	13.2
65 to 74	1.6	1.5	12.2	19.6	—	3.5	8.7	21.5

*Standardized for age on the basis of the Standard Million Population of England and Wales, 1901.

general population of the United States.

The recent decline among the policyholders favored each color and sex group, as may be seen in Table 1. Special interest attaches to the very material reduction in mortality at each age period among women, among whom the deaths from toxic goiter are largely concentrated. Few diseases exhibit such large excess of mortality among females as compared with males.

In view of the geographic variation in the death rate from toxic goiter, it is pertinent to examine the trend in the individual States. Table 2 shows the average death rates in the general population for the periods 1939–1940 and 1944–1945. Almost all the States shared in the improvement in mortality, the largest relative decreases being recorded generally in the States with the highest death rates from the disease—the region surrounding the Great Lakes and parts of the Rocky and Appalachian Mountains. For example, Ohio and Indiana, which are in the center of the "goiter belt," registered declines of 35 percent and 55 percent, respectively, in the five-year period under review. Pennsylvania, Minnesota, Illinois, Michigan, Idaho, all with above-average death rates, registered reductions of at least 30 percent.

Data are not at hand to indicate whether the recent decrease in the mortality from toxic goiter has been due to a reduction in the incidence of the disease, or to a lowered case-fatality rate. It appears, however, that the last-mentioned factor is the more important. Certainly, recent years have witnessed marked ad-

vances in the medical treatment of thyroid conditions. Moreover, in cases where surgical intervention is required, the risk has undoubtedly been appreciably reduced. Not only has there been an improvement in diagnostic technique and surgical skill, but there has also been a wider use made of chemotherapy to combat the infections, particularly pneumonia, which may follow surgery.

In 1945 there were 2,468 deaths from toxic goiter in the general population of the United States as compared with 3,659 in 1940. There is good reason to expect that further progress against the disease will be effected in the immediate future.

TABLE 2—DEATH RATES PER 100,000 POPULATION FROM TOXIC GOITER. GENERAL POPULATION OF THE UNITED STATES, 1944-1945 AND 1939-1940

STATE	AVERAGES OF DEATH RATES PER 100,000	
	1944–1945	1939–1940
UNITED STATES	2.0	2.8
New England		
Maine	1.2	1.6
New Hampshire	1.3	2.9
Vermont	1.5	3.0
Massachusetts	1.2	1.6
Rhode Island	1.2	1.4
Connecticut	1.5	2.3
Middle Atlantic		
New York	2.2	3.0
New Jersey	2.0	2.8
Pennsylvania	2.4	3.6
East North Central		
Ohio	3.3	5.1
Indiana	2.4	5.3
Illinois	3.0	4.3
Michigan	2.4	3.7
Wisconsin	4.0	5.6
West North Central		
Minnesota	2.5	3.7
Iowa	1.8	3.4
Missouri	2.5	3.2
North Dakota	1.4	2.3
South Dakota	1.1	3.0
Nebraska	2.3	2.7
Kansas	2.1	3.1
South Atlantic		
Delaware	1.4	4.0
Maryland	1.8	2.2
District of Columbia	1.5	2.5
South Atlantic—(*Continued*)		
Virginia	1.5	2.0
West Virginia	2.2	2.6
North Carolina	1.1	1.3
South Carolina	.9	.7
Georgia	.9	1.2
Florida	1.1	1.3
East South Central		
Kentucky	1.9	1.5
Tennessee	1.6	1.6
Alabama	1.2	1.6
Mississippi	1.3	1.3
West South Central		
Arkansas	1.1	1.0
Louisiana	1.5	1.8
Oklahoma	1.3	1.6
Texas	.8	1.1
Mountain		
Montana	2.9	2.8
Idaho	2.7	4.0
Wyoming	2.0	2.4
Colorado	2.3	3.4
New Mexico	1.8	1.9
Arizona	.9	1.5
Utah	3.4	4.3
Nevada	2.6	2.7
Pacific		
Washington	2.0	4.0
Oregon	2.2	3.5
California	1.6	2.0

Comparative Data on the Causes of Death Among Industrial Policyholders

The following table shows the mortality among Industrial policyholders for October 1947 and October 1946, together with the death rates for the first ten months of 1947, 1946, and 1945.

DEATH RATES* PER 100,000 POLICYHOLDERS FROM SELECTED CAUSES
WEEKLY PREMIUM-PAYING INDUSTRIAL BUSINESS
METROPOLITAN LIFE INSURANCE COMPANY

CAUSE OF DEATH	ANNUAL RATE PER 100,000 POLICYHOLDERS*				
	October 1947	October 1946	Year to Date: End of October		
			1947	1946	1945
ALL CAUSES—TOTAL	692.0	679.4	730.7	755.7	840.1
—Excluding war deaths	*691.5*	*677.3*	*730.0*	*741.2*	*739.9*
Typhoid fever	0.3	0.3	0.2	0.2	0.3
Measles	—	.1	.2	.7	.2
Scarlet fever	.1	.1	.1	.1	.3
Whooping cough	.5	.2	.5	.6	.8
Diphtheria	.3	.6	.6	.6	.8
Influenza	.8	1.5	2.9	4.8	3.2
Pneumonia (all forms)	16.4	20.3	23.0	26.5	27.0
Tuberculosis (all forms)	33.9	37.5	34.8	37.8	37.4
Tuberculosis of respiratory system	30.3	34.8	31.5	34.3	33.7
Syphilis	5.8	6.7	7.7	8.0	8.4
Acute poliomyelitis	.6	3.2	.5	1.3	.9
Cancer (all forms)	118.6	109.6	119.5	114.5	111.8
Diabetes mellitus	27.6	21.3	26.8	26.4	24.9
Cerebral hemorrhage	65.2	60.2	68.0	67.0	66.5
Diseases of the coronary arteries and angina pectoris	71.9	67.4	77.8	71.0	66.7
Other chronic heart diseases†	144.3	137.0	160.6	161.9	157.3
Diarrhea and enteritis	2.4	2.2	2.9	2.5	3.6
Appendicitis	2.3	3.1	3.1	3.5	5.1
Chronic nephritis	32.8	35.8	40.4	42.3	43.7
Puerperal state—total	2.3	3.5	3.2	3.2	3.5
Suicides	7.1	6.8	7.3	7.4	6.3
Homicides	3.2	4.3	3.9	4.1	3.1
Accidents—total	41.8	46.4	45.1	49.1	55.4
Home accidents	7.0	7.3	9.5	10.4	9.9
Occupational accidents	4.8	5.9	5.3	4.9	5.1
Motor vehicle accidents	14.7	16.7	15.2	15.9	13.7
War deaths (enemy action)	.5	2.1	.7	14.5	100.2
All other causes of death	113.1	109.2	101.3	107.6	112.8

*The rates for 1947 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†International List (1940) titles 92, 93 (c), (d), (e), and 95.

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MORTALITY FROM ALL CAUSES

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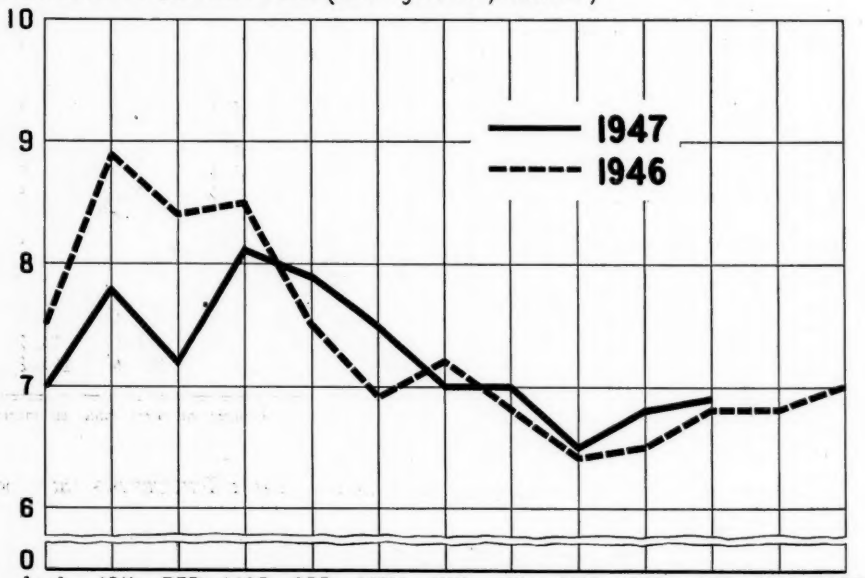
INDUSTRIAL DEPARTMENT, WEEKLY PREMIUM-PAYING BUSINESS

DEATH RATES PER 1,000 ANNUAL BASIS (*1947 figures are provisional*)



	(DEC)	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1946		8.9	8.4	8.5	7.5	6.9	7.2	6.8	6.4	6.5	6.8	6.8	7.0
1947		7.8	7.2	8.1	7.9	7.5	7.0	7.0	6.5	6.8	6.9		

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